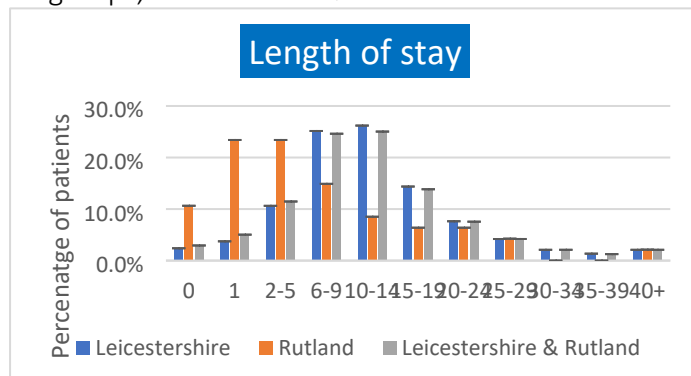


## Understanding Hip Fractures Data Rutland

Recent Public Health Data sourced from 2020- 2021 stated hip fracture rates in Rutland are significantly worse than England for people aged 80+. Hospital admission rates for hip fracture in persons 65 years and over are also significantly worse than England. Source: Fingertips, accessed on 17.08.22.



With most Rutland cases resulting in a hospital stay of 1-9 bed days this is a cost of £400 - £3600 per patient plus the additional cost of surgery and ongoing outpatient care.

To gain a better local understanding of our hip fracture risks, rate, and explore outcomes all known falls resulting in hip fractured were recorded in April to October 2023. This is to demonstrate the efficacy of our current therapy offer and identify any gaps.

16 fractures were recorded in the 7-month period.

### Themes

#### Types of falls recorded.

**12 Anticipated Falls** - adults who have *risk factors for falls that can be identified in advance.*

Multiple health conditions, cognitive impairment, frailty /advanced age

8 were unwell at the time of the fall (67%)

4 lacked capacities at the time of the fall (33%)

All aged 65+ (100%)

9 aged 80+ (75%)

**4 Accidental Falls** occur in the presence of environmental hazards.

4 trips. 3 of whom achieved **100% reablement.**

All aged 65+ (100%)

3 aged 80+ (75%)

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### Location of falls

3 falls were recorded in care settings.

(19%) significant as nationally there are 10 times more hip fractures among older people living in care homes compared with older people living in other environments. The Personalised Falls Prevention strategy is live in all care homes in Rutland and is delivering on

10 falls were recorded in the person's own home.

Only 3 of these were accidental falls where environment could be a causative factor.

3 falls were recorded elsewhere.

1 accidental fall where environment could be a causative factor.

2 anticipated falls included one in hospital.

We are committed to strengthening our falls prevention and falls recovery work in the community, alongside the focussed care settings work, with a comprehensive Adult Social Care (ASC) Therapy service and strong integration with our health partners to maximise the falls offer for Rutland.

### Current Falls offer in Rutland.

Service	Descriptor
Reablement	In addition to supporting D2A process this service supports with step up approach to prevent a hospital admission following a fall. It is a highly effective service rating above the national average for effectiveness and maintaining people at home after discharge.
Housing MOT	This is a home check service which provided information advice and support to help residents to maintain their independence and live as safely as possible in their own homes, including advice on falls prevention.
Active Rutland	Steady Steps is a 24-week programme for those who have previously fallen or worry about falling. Delivered by Level 4 specialised Postural Stability Instructors, the classes are tailored to everyone's abilities. People are eligible for the Steady Steps programme if they are aged over 65, are at risk of falling or have fallen less than three times in the past 12 months.
Care Technology Service	A commissioner service specific to the delivering digital technologies to improve independence

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	and prevent falls. This includes fall prevention specific technology such as falls detection devices, sensors and health monitoring.
Health and Prevention Grant	Discretionary grant which supports our health, wellbeing, and prevention priorities. Non financially assessed it offers necessary and appropriate adaptations/equipment efficiently which can reduce falls risk by creating a safer home environment, facilitate discharge from hospital or make a carers role more sustainable.
Raizer chair falls recovery	The ASC Therapy service identifies high risk/frequent fallers. If appropriate a raizer chair and appropriate training is provided. The service aims to support self-management of falls that do not require medical attention, reducing risk of long lies, pressures on emergency services and support to a carer role.
Falls Recovery Service	There is a direct referral route from the Falls recovery service into Adult Social Care Therapy. This enables monitoring the number of falls. Early identification of those falling in the Community. Wrap around therapy services from our current offer
Referral Falls Clinic	LPT specialist falls clinic

### Summary of themes

The data identifies the falls prevention work in the community and care settings is effective. Where preventative intervention is possible for accidental falls, we achieve good reablement outcomes (100%) This level of outcome effectiveness lessens the likelihood of reoccurrence.

Unfortunately, not all falls are preventable especially where declining cognition and poor health outcomes are the cause and the fall a symptom of these conditions. We will continue to work with our health partners to strengthen our compensatory offer in this area.

# Understanding Hip Fractures Data Rutland

## Appendix 1

### The data \*

Date	Location of Fall	Age	Comorbidities	Pathway / Outcome
20/04/2023	Tix over	93	Parkinsons Increased risk of UTI	Safeguarding recommendations Discharged back to care home to increased nursing care
28/04/2023	Chater Lodge	82	Cognitive impairment. Lacks capacity.	Safeguarding recommendations Discharged back to care home.
07/05/2023	Own home	96	Vascular dementia Lacks capacity. Registered blind Deaf	Discharged to care setting
23/05/2023	In hospital	88	Congestive Cardiac failure Pneumonia	Discharged to care setting
05/05/2023	Own home	89		Lifeline alerted assistance. Therapy reablement 100% Achieved
24.06.2023	On holiday	88		Reablement 100% achieved
14.06.2023	Outdoors	84		Receiving end of life care
24.07.2023	Rutland Care Village	74	Dementia Lacks capacity	Discharged back to care home. Safeguarding concerns proceeded to section 42.
06/09/2023	Tripped over in kitchen at home	79		Reablement 100% achieved
06/09/2023	Fall from bed	82	Diabetic Hypothyroidism Bleed on brain 2022 Permanent catheter	Discharged to care setting
10/09/2023	Fell out of chair	79	Heart Failure	Reablement
14/08/2023	Fell over the dog at home	82	Osteoporosis Asthma	Community Therapy
01/09/2023	At home	93	Dementia Lacks capacity. Atrial fibrillation	Discharged to live in care at home
20/09/2023	Fell at home as dizzy getting up	70	Ca Lung Hypothyroidism Osteopenia Peripheral Neuropathy	Reablement ongoing
21/10/2023	At home	94	Atrial Fibrillation Pressure sores Frailty	Reablement ceased care required.
23/10/2023	Fell at home in night getting to bathroom	84	Chronic kidney disease High BP COPD Osteoarthritis	Reablement – making good progress.

\*Coded by colour as per report